ATTACHMENT 2a

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
129

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow
Anytown, WI 55555

5 DATE OF BIRTH
01/12/82

6 SEX
M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE
In-Home Treatment Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
87654321

10 DX: PRIMARY
313.81

11 DX: SECONDARY
N/A

12 START DATE OF SOI

13 FIRST DATE RX

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W7027		4	1	In-home: Certified Therapist	16	
W7028		4	1	In-home: Second Team Member	32	
W7029		0	1	In-home Travel: Certified Tx	4	
W7030		0	1	In-home Travel: Second Tx	12	
					TOTAL CHARGE	21

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MMDDYY (DATE)

24 _____ (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED

GRANT DATE _____ EXPIRATION DATE _____ PROCEDURE(S) AUTHORIZED _____ QUANTITY AUTHORIZED _____

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE _____ CONSULTANT/ANALYST SIGNATURE _____